Exact Care Pharmacy

Request to Designate a Personal Representative to Have

ACCESS TO RECORDS

Section 1: Patient's Personal Information

Name: ______________________ DOB: ______________________

Address: ______________________ Telephone: ______________________

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I understand that upon granting access to requested records, the facility will update our records within thirty (30) days of receipt of request. This request will remain in effect for the designated individuals until such time as a Request for Restriction of Uses and Disclosure is received. Effective April 14, 2003, the facility will retain PHI records and associated documents for six (6) years from the date of last action.

Section 2: Authorization to Designate Personal Representatives to Access Your Protected Health Information

Name	Relationship/DOB	Address

*I am **AUTHORIZING** the individual(s) listed above to have access to my Protected Health Information (PHI) and they may request PHI, limited data sets or any other information or document. My signature indicates my authorization for PHI to be released to myself and/or to the designated individuals listed above.*

Date: ____________ Signature: ______________________ Relationship to Individual: ____________

Date: ____________ Witness Signature: ______________________

Submit this completed request to the facility or mail to:

Exact Care Pharmacy
Todd Donnelly
8333 Rockside Rd
Valley View, OH 44125-6126

***Office Use Only* – Please Do Not Write Below This Space**

Date Request Received: ____________ By: ______________________

❑ Notice of Acceptance Mailed ❑ Notice of Denial Mailed